Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CLEAR LAKE REGIONAL MEDICAL CENTER

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-13-1148-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JANUARY 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.401…TDI, DWC does not have a fee guideline for inpatient rehabilitation facilities. In absence of a negotiated contract, those services would be reimbursed at 'fair & reasonable' in accordance with Rule 134.1. Therefore, our client's claim would be reimbursed at 'fair & reasonable' at 100% of total billed charges."

Amount in Dispute: $11,962.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TDI-DWC has not established a fee schedule guideline for Inpatient Rehab therefore payment would be reimbursed at a 'fair & reasonable' or a negotiated amount. Per the preauthorization approval letter, a negotiated per diem payment of $1,152.33 all inclusive was agreed upon. (See Item 1)

TASBRMG reimbursed 6 days at the agreed per diem rate of $1,152.33 to equal a payment of $6,913.98. We feel payment was reimbursed correctly; the provider was notified of the negotiated agreement on the preauthorization letter."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2012 through January 20, 2012	Inpatient Rehabilitation Hospital Services	$11,962.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404, effective March 1, 2008, provides for the reimbursement guideline for acute care inpatient hospital services.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment. Re-priced in accordance with the DRG rate.
   - 193-Original payment decision is being maintained. Upon review it was determined that his claim was processed properly.
   - 05/31/12: Maintain original audit; paid at fair and reasonable per agreement.

Findings

1. According to the explanation of benefits, the services in dispute were paid at fair and reasonable per agreement. The respondent states that "Per the preauthorization approval letter, a negotiated per diem payment of $1,152.33 all inclusive was agreed upon." The insurance carrier failed to provide a copy of a signed agreement between the parties for this rate. For that reason, the disputes health care will be reviewed in accordance with applicable division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(a) states "Applicability of this section is as follows. (1)This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008."

   28 Texas Administrative Code §134.404(b)(1) states "'Acute care hospital' means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma."

   The requestor provided inpatient rehabilitation services; therefore, the guidelines of 28 Texas Administrative Code §134.404 are not applicable.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that fair and reasonable reimbursement would be 100% of total billed charges.
   - The requestor did not support position that additional reimbursement of $11,962.02 would be a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this

dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		04/17/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.